

UTAH STATE DEPARTMENT OF HEALTH
Division of Children's Services
44 Medical Drive
Salt Lake City, Utah
84113

Application for Services

Name _____ Parent Name _____

Address _____ City _____ County _____

Date of Birth _____ Sex _____ Race _____ Telephone _____

History (brief outline of presenting problem, including reason for referral)

Physical Examination:

General Appearance: _____

Head, EENT: _____

Chest: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Tentative Diagnosis: _____

Parent consent for referral:

We authorize the Division of Children's Services of the Utah State Department of Health to perform the necessary diagnostic examination to recommend treatment or to recommend and provide treatment for the above child.

Signature: _____
Parent or Legal Guardian

Physician's request for referral:

- ☐ Diagnostic Consultation
- ☐ Diagnostic consultation and treatment (should patient meet the eligibility requirements)

Signature _____ M.D.

Address _____

Date _____

Please send application to:

Utah State Department of Health
Division of Children's Services
44 Medical Drive
Salt Lake City, Utah 84113

Telephone 322-2431

Additional forms may be obtained by physicians at above address.

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